ORTHOTIST & PROSTHETIST – APPLICATION FOR LICENSURE

ATTACH CHECK HERE

GEORGIA MEDICAL BOARD (GMB) USE ONLY

APPLICATION NUMBER		**FILE NUMBER**	
RECEIVED		**COMPLETED**	
TEMP LICENSE #		**DATE ISSUED**	
LICENSE NUMBER		**DATE ISSUED**	

ALL FEES ARE NONREFUNDABLE*

F E E S A R E S U B J E C T T O C H A N G E

Application Category: Please check one or more of the boxes below:

I would like to apply for licensure for:

_____ Orthotist
_____ Prosthetist
_____ Orthotist/Prosthetist

Based on:

_____ ABC Certification
_____ BOC Certification

Please be aware that falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying or revoking a license.

BASIC INFORMATION

PLEASE <u>PRINT</u> CLEARLY OR TYPE IN BLACK INK.

1. US Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also may be disclosed to the Healthcare Integrity and Protection Data Bank (HIPDB) or other state medical boards or regulatory agencies for license tracking purposes.

2. LAST NAME	FIRST NAME	MIDDLE NAME	DEGREE

MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	

3. Mailing address – This address will be used to mail application status information.			
STREET NUMBER STREET NAME			APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
( ) (AREA CODE) PHONE NUMBER	( ) (AREA CODE) FAX NUMBER (OPTIONAL)		@ E-MAIL ADDRESS (**optional)**

4. Practice street address – This address will appear on the internet.			
STREET NUMBER STREET NAME			SUITE #
CITY	STATE	ZIP CODE	COUNTY
( ) (AREA CODE) PHONE NUMBER	( ) (AREA CODE) FAX NUMBER		

CERTIFICATION INFORMATION

5. Have you passed a national certification examination? ☐ **YES** ☐ **NO**

If yes, which examination:

_____Certification by the American Board for Certification in Orthotics and Prosthetics, Incorporated (ABC).

_____Certification by the Board of Orthotist/Prosthetist Certification (BOC).

☐ **Other** Please list:_____

DATE OF CERTIFICATION:_____

If no, indicate the date you are scheduled to sit and the name of examination:

Date Scheduled:_____ Examination Type:_____

APPLICANT QUESTIONNAIRE –

INSTRUCTIONS: If you answer, "YES" to questions 1-12, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish complete documentation may result in a delay in the processing of your application. I understand that my questionnaire may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and may result in criminal penalties, up to and including reporting to the Health Integrity and Protection Databank (HIPDB).	**YES**	**NO**
1. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (Provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	❑	❑
2. Have you ever been arrested and/or convicted of a violation of any Federal (including military), State or Local statute?	❑	❑
3. Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	❑	❑
4. Has any licensing Board or agency ever denied you a certificate or a license?	❑	❑
5. Has any licensing Board or agency ever taken disciplinary action against you?	❑	❑
6. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑
7. Have you ever been denied membership in or in any way sanctioned by any Orthotics and/or Prosthetics association, society, or specialty society?	❑	❑
8. Have you ever voluntarily surrendered a license?	❑	❑
9. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑
10. Do you have any applications for licensure pending before any other licensing Board or agency?	❑	❑
11. Have you ever been convicted of Medicaid or Medicare fraud, or had any restrictions as a Medicaid or Medicare provider?	❑	❑
12. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑

LICENSE HISTORY	
INSTRUCTIONS: If you are now or have ever been licensed to practice as an Orthotist or Prosthetist in another state, original verifications of license history certification is required for each permanent, temporary, training, provisional, or limited license obtained in any state in the US or Canadian territory, Canadian province, or US Federal jurisdiction. The issuing authority should mail the verification to the Medical Board. If licensed by examination, give the state. If licensed by reciprocity, provide the state. Provide the current status of the license: active, inactive, revoked, suspended, probation, limited, etc. You may make copies of this page if more space is needed. Please complete FORM C and forward to the issuing State to request verification be sent "directly" to the Medical Board.	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	
STATE/COUNTRY	
DATES OF LICENSURE	(MM/DD/YY TO MM/DD/YY)
LICENSED BY	
CURRENT STATUS OF LICENSE	

AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼" X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

BOTTOM OF PHOTO (SHOLDERS)

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Orthotist and Prosthetist Licensure Information and Applicant instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Orthotics and Prosthetics Practice Act, and the Board Rules.

I further state that by filing this application for license to practice orthotics and prosthetics in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Composite State Board of Medical Examiners for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of licensure in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite State Board of Medical Examiners any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge, and exonerate the Georgia Composite State Board of Medical Examiners, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite State Board of Medical Examiners.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that false swearing may constitute a felony offense under O.C.G.A. 16-10-71. I understand that working and falsely presenting myself to the public as licensed to practice as an orthotist and/or prosthetist is a violation of the Orthotics and Prosthetics Act and is a misdemeanor.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application for a license to practice orthotics and prosthetics in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed to me this _____day of _____, _____

_____(Notary Public)

My Commission Expires

_____

FORM A – APPLICANT WORK HISTORY –
ORTHOTIST AND PROSTHETIST LICENSURE

Work History: Orthotist and Prosthetist

APPLICANTS: Please complete your work history only as it relates to the practice of orthotics and/or prosthetics. For non-O & P related employment, please list the employer, dates employed, and job title. DO NOT list your job duties.

1. LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	DEGREE (MD OR DO)

	SEX M F	SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __	DATE OF BIRTH (MM/DD/YY) __ __ / __ __/ __ __ __ __ CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

STREET NUMBER	STREET NAME	APARTMENT #

CITY	STATE	ZIP CODE	COUNTY

2. RECORD WORK HISTORY CHRONOLOGICALLY – Complete Work History beginning with present employment. You must account for all breaks in work history, including, volunteer work and periods of unemployment.

E-MAIL ADDRESS

A. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

B. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

C. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT:	

TO: _____/_____/_____ MONTH DAY YEAR	____FULL-TIME ____PART-TIME	
D. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

Applicant Signature: _____ Date:_____

If self-employed, check here:_____

FORM B
REFERENCE FORM – ORTHOTIST AND PROSTHETIST LICENSURE

To Applicant: The GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS requires completion of three **(3)** reference forms. Formal letters of reference are not accepted in lieu of the Reference Form since questions on the form are required by the Board. Have the reference sources complete the form and send it directly to **you. Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

Please mail your form with your application packet to:

Georgia Composite State Boards of Medical Examiners
A T T E N T I O N : O R T H O T I S T A N D P R O S T H E T I S T L I C E N S U R E
2 Peachtree Street, NW - 36th Floor
Atlanta, GA 30303

In addition, the reference forms must come from the following individuals:
a. **2 references from current or former patients for whom you have provided services**.
b. **1 references from referral sources (i.e., physicians, physical therapists, case managers, etc.)**
c. If self-employed, please check here. _____ (if checked, only 2 references will be required.
d. The Board **does not accept faxed copies of the reference form**.

Applicant, be sure to indicate your name and address below for identification purposes.

NAME OF APPLICANT: _____

ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

To Reference Source: Please complete this form, sign, and return to the **applicant** in a **sealed envelope** at the above stated address. Your response is confidential, pursuant to Georgia law. All applicants are required to sign a general release, which relieves anyone of any liability for information furnished in good faith. Please print or type all information. Please make sure the applicant's name is indicated on the form. **Sign your name across the back of the envelope.** The processing time for licensure directly depends on timely receipt of critical forms such as this.

ATTENTION: *The person who signs this form **MAY NOT** be related to the applicant by blood, marriage, or adoption, unless the person is your current employer.*

THIS POINT FORWARD IS TO BE COMPLETED BY THE REFERENCE SOURCE:

Please **print legibly:**

From: _____
First Middle Initial Last Degree

_____
Address City State Zip

_____
Area code Phone Number

_____
Area code FAX Number

FORM B - CONTINUED
REFERENCE FORM – ORTHOTIST AND PROSTHETIST LICENSURE

PLEASE CONFIRM THAT THE FOLLOWING RESPONSES ARE CORRECT BEFORE SUBMITTING THIS FORM. INAPPROPRIATE ANSWERS WILL RESULT IN A DELAY IN PROCESSING THE APPLICATION.

Standard Questions

		Yes	No
1.	Have you ever received reports of poor clinical practice by this individual, or have you discussed concerns you had about this individual?	❑	❑
2.	Have you ever received reports of poor relationships between this individual and other members of the clinical staff?	❑	❑
3.	Are you aware of any derogatory information about this individual with respect to his/her ability to practice?	❑	❑
4.	Does this individual have, or has this individual had in the past, any mental or physical illnesses or personal problems that interfere with his/her practice?	❑	❑
5.	Has this individual ever abused alcohol or drugs or shown signs of chemical dependency?	❑	❑
6.	Are you aware of any lawsuits having to do with his/her practice that this individual has either lost or settled out of court?	❑	❑
7.	Are you aware of any restrictions, limitations or other actions of any nature taken against this individual by a health related entity?	❑	❑

Personal Information

1. How long have you known this practitioner? _____

2. Please explain your relationship to this practitioner.

_____

_____

3. In what capacity has this person worked with you?

_____

4. Describe your experience with this person.

_____

_____

5. Would you refer someone to this practitioner for treatment? ____YES ____NO

6. Do you recommend this individual for unrestricted licensure in Georgia? ____YES ____NO

_____
SIGNATURE

_____
Phone Fax

P

FORM C
LICENSE VERIFICATION

To be completed by the applicant. Original verification history of all licenses you have held or currently hold is required – even if you have not worked in that state for 20 years or you got a license and never practiced in that state. List the State/Country, dates of licensure, licensed by examination, reciprocity, state board examination. This form should be sent to each state in which you are now or ever have been licensed to practice. **This form may be photocopied.**

TO: _____ Board

FULL NAME	STREET ADDRESS	APT. NO.
SIGNATURE	CITY	STATE ZIP

The individual listed above has applied for licensure in Georgia. Before further consideration is given to this application, we need the information requested on this form. By signing this form, I give my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure. Please mail the completed form as soon as possible to the Board at the address listed below.

Section II: This Section to be completed by an official of the above referenced Licensing Board. Do not return this form to the applicant, but mail it directly to:

Georgia Composite State Board of Medical Examiners
ATTN: ORTHOTIST & PROSTHETIST LICENSURE UNIT
2 Peachtree Street, NW - 36th Floor
Atlanta, Georgia 30303

Title of License: _____ License number: _____

Original issue date: _____ Expiration date: _____

License status: [ ] Active [ ] Inactive [ ] Temporary [ ] Other

Licensure Method: [ ] Grandfathering [ ] Endorsement [ ] Examination

1. Has any disciplinary action ever been taken again this license? [ ] YES [ ] NO

If YES, provide the board with any documentation regarding the disciplinary action.

2. Do you have derogatory information concerning this applicant? [ ] YES [ ] NO

_____ _____
Print Name Date

_____ _____
Signature Office Number

_____ _____
Title Fax Number

_____
State Board

BOARD SEAL MUST BE IMPRINTED HERE

FORM D
VERIFICATION OF EXAMINATION
RELEASE OF INFORMATION
AMERICAN BOARD FOR CERTIFICATION IN ORTHOTICS AND PROSTHETICS, INC. (ABC).

PLEASE SEND THIS FORM DIRECTLY TO THE AMERICAN BOARD FOR CERTIFICATION IN ORTHOTICS AND PROSTHETICS, INC. (ABC).

ORTHOTIST AND/OR PROSTHETIST: Please complete the top half of this form prior to mailing to the ABC.

Social Security Number: _____

Last Name	First Name	Middle Initial

Address	City	State	Zip Code

The undersigned authorizes the ABC to release to the Composite State Board of Medical Examiners (CSBME), the information requested below:

_____ _____
Applicant's Signature Date Signed

TO: COMPOSITE STATE BOARD OF MEDICAL EXAMINERS (CSBME)

As Registrar of the American Board for Certification in Orthotics and Prosthetics (ABC), I hereby attest that the above named applicant was certified on _____ and is currently certified by the Board until _____.

ABC Certificate #_____.

_____ _____
Signature Date Signed

COMMISSION SEAL

PLEASE RETURN THIS FORM DIRECTLY TO:
Composite State Board of Medical Examiners (CSBME)
Attention: Orthotist and Prosthetist Licensure Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303

FORM E
VERIFICATION OF EXAMINATION
RELEASE OF INFORMATION
BOARD OF ORTHOTIST/PROSTHETIST CERTIFICATION (BOC).

PLEASE SEND THIS FORM DIRECTLY TO THE BOARD OF ORTHOTIST/PROSTHESTIST CERTIFICATION (BOC).

ORTHOTIST AND/OR PROSTHETIST: Please complete the top half of this form prior to mailing to the ABC or BOC.

Social Security Number: _____

Last Name	First Name	Middle Initial

Address	City	State	Zip Code

The undersigned authorizes the **BOC** to release to the **Composite State Board of Medical Examiners (CSBME)**, the information requested below:

_____ _____
Applicant's Signature Date Signed

TO: COMPOSITE STATE BOARD OF MEDICAL EXAMINERS (CSBME)

As Registrar of the Board of Orthotist/Prosthetist Certification (BOC) I hereby attest that the above named applicant was certified on _____ and is currently certified by the Board until _____.

BOC Certificate #_____.

_____ _____
Signature Date Signed

COMMISSION SEAL

PLEASE RETURN THIS FORM DIRECTLY TO:
Composite State Board of Medical Examiners (CSBME)
Attention: Orthotist and Prosthetist Licensure Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303